MAINE STATE BOARD OF NURSING
158 State House Station
Augusta, ME 04333-0158

VERIFICATION OF REGISTERED NURSE LICENSURE

TO _____ Board of Nursing

Name of Applicant _____
First Middle Maiden Last

Present Address _____

License Number _____ Birth Date _____ Social Security Number _____

Information below to be completed by Board of Nursing in your State of original licensure

High School Diploma: Yes _____ No _____ Equivalency _____

Nursing Program: Name _____

Location _____

State Accredited: Yes _____ No _____ Length of Program _____

Date of entrance _____ Date of completion _____

Associate degree _____ Baccalaureate degree _____ Diploma _____

License number _____ Date issued _____ Date current license expires _____

Issued on the basis of examination _____ ; endorsement _____ ; waiver _____.

Has license ever been suspended, revoked, probated, reprimanded or limited/restricted? Yes _____ No _____
If yes, please attach explanation.

*Results of State Board Test Pool Examination/NCLEX

Series Number _____

Scores:

*Please indicate if examination was taken more than one time.

Medical Nursing _____

**If applicant did not write SBTPE/NCLEX, specify type of test and list subjects and grades on back.

Psychiatric Nursing _____

Obstetric Nursing _____

NAME _____

Surgical Nursing _____

TITLE _____

Nursing of Children _____

STATE _____

Comprehensive NCLEX _____

DATE _____

Canadian Examinations:

CNATS_____ Provincial_____

Taken in English _____ French _____

(SEAL)